Account _____

Client Account Set Up Form
6781 Londonderry Way Suite 4
Union City, GA 30291
Phone: 770-681-0004
Fax: 678-545-1424
info@prioritytoxlab.com
www.prioritytoxlab.com

Submitted by: _____ Date Submitted: _____

Email Address:_____ Phone:_____

ACCOUNT INFORMATION:

Start Date: _____

Client/Facility Name: _____

Referring Physician(s): _____

NPI #: _____

Client/Facility Address: _____

City: _____State:_____ Zip Code:_____

Email Address: _____

Phone: _____Fax: _____

Primary Contact: _____

Primary Contact Phone: _____

Primary Contact Email Address: _____

PRIORITY Laboratories
"Your Patients, Our Priority"

Account _____

Services Requested

Infectious Disease by PCR	Please Initial
Wound	
UTI	
Nail Fungus (Coming in April!)	
COVID-19	

Toxicology	Please Initial
Drug Screen by Immunoassay	
Urine Validity by Immunoassay	
Confirmation by LC/MS/MS	

All patient samples will require an individual Requisition with patient name/dob, tests/panels ordered, diagnosis codes, and insurance information. By initialing above you are letting Priority Toxicology Laboratories know the type of testing your facility will require today or in the future. This is in no way a standing order nor is it binding.

Reporting Protocol

☐ Fax ☐ Portal

Specimen Transport

☐ FedEx ☐ UPS

Pickup Days: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Currently have daily pickups

Time Request for Pickup: _____ Office Hours: _____

Physician Acknowledgement and Consent

As a part of my practice's compliance protocols, I herby request and authorize **Priority Toxicology Laboratories, LLC**, to establish for me a customized testing panel for urine patient specimens from my practice for each of the prescription drugs and or/drug classes and illicit substance analytes selected by me.

I am authorizing **Priority Toxicology Laboratories, LLC**, to perform qualitative and quantitative testing for medications prescribed and illicit drugs when Point of Care Methods do not detect them and when I order such testing on the requisition.

In my professional judgement the test I ordered are medically necessary. I authorize Priority **Toxicology Laboratories, LLC**, to perform the Custom Profile I have created on this form, including each test checked. I understand that the patient's medical record must clearly reflect my order for testing.

I acknowledge that I can modify my custom profile for individual patients based on medical necessity by identifying a new preference on the requisition.

Physician Name (print) _____Signature_____ Date:_____

Physician Name (print) _____Signature_____ Date:_____

Physician Name (print) _____Signature_____ Date:_____

Physician Name (print) _____Signature_____ Date:_____

Physician Name (print) _____Signature_____ Date:_____